# Pediatric Intensive Care Influenza Case History Form

Cases must be 0-17 years old, have either died or are critically ill (hospitalized in the ICU), and have either 1) confirmed influenza by laboratory testing; or 2) a clinical syndrome consistent with influenza or complications of influenza (pneumonia, ARDS, apnea, cardiopulmonary arrest, myocarditis, Reye syndrome or acute CNS symptoms (e.g. seizures, encephalitis).

**Patient Information:**

Last name _____ First name_____ DOB ____/_____/____ Medical Record #_____

Street Address: _____ City _____ Zip Code _____

**Race:** □ White □ Black □ Native American
□ Asian/Pacific Islander □ Other □ Unknown

**Ethnicity:** □ Hispanic □ Non-hispanic

**Sex:** □ Female □ Male

**Clinical:**

Date onset of symptom(s): _____/_____/_____

Date of hospital admit: _____/_____/_____

**Did the patient have any of the following symptoms/syndromes during the current illness:**

Fever ≥38º □ Yes □ No _____

Lower respiratory symptoms (cough, shortness of breath, wheezing, bronchospasm) □ Yes □ No _____

Apnea □ Yes □ No _____

Nausea/vomiting □ Yes □ No _____

Altered consciousness □ Yes □ No _____

Seizures □ Yes □ No _____

Pneumonia/ARDS □ Yes □ No _____

Encephalitis/meningitis □ Yes □ No _____

2˚ bacterial pneumonia □ Yes □ No _____

Myocarditis □ Yes □ No _____

Reye Syndrome □ Yes □ No _____

Sepsis/Multi-organ Failure □ Yes □ No _____

If yes, specify _____

**Significant Past Medical History_____**

_____

_____

_____

_____

**Risk factors:**

Chronic lung/cardiac/metabolic/renal disease or blood disorder (e.g. asthma, DM, sickle cell): □ Yes □ No

If yes, specify _____

_____

Immunosuppression (e.g. HIV, malignancy, chronic steroids): □ Yes □ No

If yes, specify _____

Long -term aspirin therapy: □ Yes □ No

Pregnant: □ Yes □ No weeks:_____

Flu Vaccine? □ Yes □ No

If yes, approximate dates: 1st dose ____/____/____

2nd dose (if done): ____/____/____

Did child receive Flu Mist? □ Yes □ No.

If yes, how many doses? □ both □#1 only

Contacts with confirmed or suspected influenza?

□ Yes □ No If yes, does the contact have:

□ lab-confirmed influenza □ influenza-like illness

**Diagnostic/Laboratory Studies** (specify details):

CBC: Hct _____ Plt _____ WBC_____

diff: segs ____% bands____% lymphs ____% monos ____%
atyp lymph ____% eos ___%

Chest X-ray: □ Pos □ Neg □ Not done

Findings: _____

Cardiac echo: □ Pos □ Neg □ Not done

Findings: _____

Lumbar puncture: □ Pos □ Neg □ Not done

If yes: OP ____WBC____ RBC____ TP____ GLU____

Micro:_____

**Microbiology Testing:**

Blood culture: □ Pos □ Neg □ Not done

If positive, specify pathogen:

_____

Respiratory culture: □ Pos □ Neg □ Not done

If positive, specify specimen (n-p swab, n-p wash, o-p swab, ET aspirate, sputum, BAL, pleural fluid) and pathogen:

_____

Rapid influenza test: □ Pos □ Neg □ Not done

Rapid RSV test: □ Pos □ Neg □ Not done

**Other pertinent labs (LFTs, MRI/CT, etc.)**

_____

_____

**Clinical course:**

Antibiotics/antivirals received (if any) and dates:

_____

_____

_____

Transfusions/ECMO: □ Yes □ No

Intubated: □ Yes □ No

Died: □ Yes □ No

Date of Death ____/____/____

**Contact Physician/Infection Control Practitioner Information:**

**Name:** _____ **Facility:** _____

**Pager:** _____ **Fax:** _____ **e-mail:** _____

**For questions regarding surveillance or collection of specimens, contact your local county health department or Janice K. Louie, MD, MPH, Immunizations Branch at 510-540-3452**

**TO REPORT A CASE, PLEASE CONTACT YOUR LOCAL COUNTY HEALTH DEPARTMENT (Ph number) AND FAX THIS FORM TO:**